# Training the Pacific surgeon

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This address will highlight the problems as I see them and suggest some broad directions that can be examined. The solutions are for the conference to find and it is for the conference to determine the path we should follow. What I intend to do is to set out the broad principles of the training programmes and to look at them in relation to the problems of surgery in the Pacific.

Over recent years the training programmes of Royal Australasian College of Surgeons (RACS) have undergone considerable changes. In the past there was significant emphasis

on General surgery as the base of all training as this reflected the practice of surgery in Australia and New Zealand. Increasingly there has been a move away from this model. With increasing specialization in surgery, the training programmes are varied in content and are very specific for the specialty in which they occur. More so in Australia than in New Zealand, metropolitan General Surgery has become more specialized

with the development of Vascular Surgery as a separate division of the College and the growth of such areas as Colorectal Surgery, breast surgery and Upper GI Surgery. Outside the metropolitan areas General Surgery as traditionally practiced continues but even there is much less Orthopaedics, Urology and Paediatric Surgery are carried out by General Surgeons than there used to be.

Training programmes have followed the change in surgery of the metropolitan centres and the College now finds that its training programmes no longer produce the traditional General Surgeon. This has left the Rural Surgeons with no training programme that is suitable for their practice and the College

is now looking at ways to solve that problem. Currently all training programmes consist of firstly the requirement to complete the Part 1 package an MCQ paper and the OSCA examination in basic surgery in general. The College is moving towards a more defined curriculum for the two years of basic training required before application can be made into Advanced Training.

From there, entry in to advanced training is a competitive process with positions keenly sought. In the past advanced training consisted of relatively unstructured clinical training followed by the Part 2 Examination – the last great hurdle before qualifying as a fully trained surgeon. Now there is far more emphasis on ongoing training with close supervision by mentors and the provision of frequent mentor reports to the

training supervisors. So the examination has become slightly less important and the reporting of training progress more important. The training posts are therefore tightly structured and closely supervised. The competition for training posts, the relative shortage of surgeons in several specialties and the need for training posts to be able to fulfill fairly rigorous conditions means that it is difficult to enlarge the training pro-

grammes and more difficult than in the past to place trainees from overseas into conventional posts.

Input into training of Pacific Surgeons by Australia and New Zealand has been by several mechanisms:

- Funding surgeons to complete training programmes in Australia or New Zealand doing the whole training programme of basic and advanced training. Funding has been provided from a variety of sources – their own country, scholarships, and their own resources.
- Shorter periods of training to do part of the programme to provide skills in particular areas. These have been fitted in where it is possible but always secondary to local needs in Australia and New Zealand. More common in some specialties e.g. Orthopaedics. It has been variable in General Surgery.

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- 3. Local programmes undertaken with help from Australia and New Zealand e.g. the Orthopaedic Association assisted training programme in Fiji.
- 4. Aid programmes where surgeons from Australia and New Zealand travel to Pacific countries to undertake clinical work and teach. Examples are Interplast, NZ Government aid programmes and AusAID now with a significant resource managed by the College through its Pacific Island Project. Although the teaching during these programmes may be valuable their main focus is on clinical work and the teaching is variable and not co-ordinated.

### **RACS** view

Although a significant amount of teaching and training has been carried out, the above mechanisms are not the most appropriate for the future. And the way it has been carried out in the past has led to several problems:

- Taking surgeons away from their country for overseas training depletes the surgical workforce. Countries can not afford to lose even temporarily, significant numbers of their surgeons, even when they are only partially trained.
- 2. The training provided in other countries is often not relevant for practice in the Pacific. As mentioned above much of the College training in Australia and New Zealand is highly specialized, orientated to high tech surgery, teaching procedures that may not be appropriate for social and economic reasons in the Pacific. As

well the tropical island countries have a range of diseases not seen in Australia and New Zealand.

 Historically many surgeons when they have finished their training do not return to their home country thus depleting

the workforce.

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4. The training programmes are difficult for trainees to complete. They may have to be separated from their families and cultures – and the failure rate is high. They can often go only at considerable cost to themselves. This is not to say that they can't do it – many have done; but they are at a disadvantage compared with local graduates.

## What are the solutions?

### **Principles**

Pacific surgeons must be trained appropriately for the surgery they undertake in their countries. They must obtain qualifications that are relevant to their work and indicate their competence to undertake the surgery they encounter in the Pacific Surgery in PIC should be regarded as a specialty, much as the rural surgeons in Australia and New Zealand have been. The training should be PIC based and carried out with assistance in developing training programmes from outside. The training must relate to the work they are to carry out.

# Other problems that need to be addressed

- 1. There are too few surgeons and too few permanent surgeons.
- For surgeons to be returned, they need adequate terms and conditions of employment and adequate remuneration. Failure to address these will lead to loss of surgeons.
- Many surgeons in practice have to work with inadequate equipment.
- 4. If there is no local training, this decreases the attraction to local graduates particularly if there is little opportunity to train elsewhere. Thus the best medical graduates may not be attracted into surgery.

## How can the College help?

It is not for the College to indicate what is necessary. We are willing and able to assist in development of locally based programmes and qualifications. The College has expertise in the design of courses and examinations and the ability to develop educational programmes.

Once trained appropriately for the work they have to do

surgeons all know that the process of their personal education is life long. One of the fascinations of surgery is that we are all constantly learning. My belief is that you don't have to require learning by surgeons but you do have to provide appropriate circumstances for it to occur.

Australia and New Zealand societies no longer accept as an article of faith that surgeons automatically remain competent for the rest of their lives and they require evidence that they are continuing with their education and keeping up to date. This fact has led the College (and all other Medical Colleges) to set up formal recertification programmes. The essential

items of the College Recertification Programme is the requirement of a defined amount of continuing education and the gathering together of surgeons to look at the quality of care they provide for the patients.

Pacific surgeons are in just as much need of these aspects of their professional lives as are Australian and New Zealand

surgeons. The problems in providing such programmes and facilities are huge because of two factors – distance and funding. But because it is difficult does not mean the need is not there and because it is difficult we should look for different ways of achieving the same end.

We can look at ways in which meetings such as this can be held more regularly – personal contact is undoubtedly the best. But it is expen-

sive. We can provide continuing education modules - e.g. Anaesthetic continuing education programme.

For the price of a couple of air fares to New Zealand - a surgeon could be provided with a computer, a modem and instant electronic access to a vast store of medical knowl-

edge, of up to date management of instant access to colleagues and friends at any place in the world. It would allow communication amongst groups and sharing of educational tools that we are only just beginning to learn how to use. I believe that this will be the way to solve the professional isolation of the Pacific Surgeon in the near future. It is not expensive in terms of aid programmes. The College can play

a role in the development of this as this is just the direction the College itself is beginning.

This conference is about solving the urgent problems that are here. I hope I have highlighted them in a way that is recognizable and familiar to you all. I have given you my view on a general direction that can be taken – it is for this conference to decide the specifics. I have given you a glimpse into what I believe the future holds and the way

in which the seemingly insuperable problem of distance and resources may be partially overcome.

I know this conference will be a landmark conference for the future of surgery in the Pacific.  $\Box$ 

"It is ... sometimes easier to head an institute for the study of child guidance than it is to turn one brat into a decent human being."

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J. W. Krutch (1893 - 1970)

In: 'If You Don't Mind My Saying', "When Do We Picket Tonight"